Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTHEAST HEALTH SERVICES
PO BOX 453062
GARLAND TX 75045

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TRAVELERS PROPERTY CASUALTY CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-06-5888-01

MFDR Date Received

MAY 15, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "These claims were originally denied as 'entitlement'. Since then the patient attended a BRC that determined that the patient did sustain a compensable injury on 5/3/05. Please see attached BRC decision. Please reprocess these dates of service based on the attached BRC decision."

Amount in Dispute: $105.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "**ISSUE 2**---Adjuster Karen Perea has reviewed the file. The bilateral cubital tunnel syndrome and right carpal tunnel syndrome were found compensable. The provider has included on the following bills body areas that were not compensable. Her findings and decision is the same for the following dates of service. The following quote is from the adjuster 3-mail to Kathy Walicek June 7, 2006 11:03 am. 'I spoke with Margaret Dailey at [phone number]; confirmed the only compensable injury is cubital tunnel syndrome. Margaret agreed to review their notes and determine the treatment to the wrists only and also advise Jennifer Davis ([phone number]; responsible person in their office for submitting the DWC 60) of the corrected billing to be submitted and to withdraw the DWC 60. I also will attempt to call Jennifer today.'"

Response Submitted by: St. Paul Travelers, 1301 E. Collins Blvd, Richardson, TX 75081

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 1, 2005 July 5, 2005 July 12, 2005	CPT Code 98943	$105.00	$35.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines.
3. 28 Texas Administrative Code §133.1 sets out the definitions for Chapter 133, Benefits – Medical Benefits.
4. 28 Texas Administrative Code §134.1 sets out the procedure for fair and reasonable reimbursement.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W11 – Entitlement to benefits, not finally adjudicated. Not reimbursable because the workers compensation claim has been denied based on compensability, disability or a combination of reasons.

Issues

1. Was the compensability issue resolved?
2. Are the disputed services related to the compensable injury?
3. Did the requestor bill the disputed services correctly?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the services in dispute using denial code W11 – Entitlement to benefits, not finally adjudicated. Not reimbursable because the workers compensation claim has been denied based on compensability, disability or a combination of reasons. According to the Contested Case Hearing decision and order dated November 17, 2005, "The claimant sustained a compensable repetitive trauma injury, with a date of injury of May 3, 2005. The claimant had disability within the meaning of the Texas Workers' Compensation Act, from May 5, 2005 through the date of the hearing. Carrier is ordered to pay benefits in accordance with this decision, The Texas Workers' Compensation Act, and the Commissioner's Rules." Therefore, the disputed dates of service are eligible for review in accordance with applicable Division rules and fee guidelines.
2. The disputed service is CPT Code 98943. According to AMA Current Procedural Terminology, CPT @005 Professional Edition this code is defined as extraspinal, one or more regions. The five extraspinal regions referred to are: head (including temporomandibular joint, excluding atlanto-occiptial) region; lower extremities; upper extremities; rib cage (including costotransverse and costovertebral joints) and abdomen. Upper extremity categories are: arm, axilla, elbow, forearm, hand and shoulder. Review of the submitted progress notes supports that the treatment was rendered as billed.
3. In accordance with 28 Texas Administrative Code §133.1(a) the following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise: (3) Complete medical bill – A medical bill that: (B) is on the Commission-prescribed form and that includes the information required by the instructions for the form. Review of the submitted CMS-1500 for dates of service July 1, 2005 and July 5, 2005 documents, in box 21, an incorrect diagnosis code. The diagnosis code listed is "0"; therefore, reimbursement is not recommended for these dates of service. Review of the CMS-1500 for date of service July 12, 2005 documents diagnosis code 842.00 – Sprain/Strain Wrist.
4. Review of the submitted documentation finds that reimbursement for date of service July 12, 2005 is recommended. In accordance with 28 Texas Administrative Code §133.307(j)(1)(F), if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code §413.011 and §§133.1 and 134.1 of this title. Review of EOBs submitted by the insurance carrier show payments were made to the requestor for treatment to this injured worker for three previous dates of service, May 31, 2005, June 6, 2005 and June 13, 2005 in the amount of $35.00. The requestor billed $35.00 for each date of service; therefore, reimbursement is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $35.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $35.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 22, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.